WE ARE YOUR DOL

NEW YORK STATE | Department of Labor

Unemployment Insurance Division
Liability and Determination Section
Harriman State Office Campus
Albany, NY 12226
(518) 457-2635

Shared Work Program Application

Instructions:

- Type or print in black ink. Complete both pages.
- Return the completed and signed form to the address above or fax to (518) 485-6172.
- **The Department of Labor must have this application by the Monday three weeks prior to the plan's start date.**
  - Applications sent four (4) weeks before the plan's start date will not be considered.

Employer Information

1. Employer name: _____
2. Employer Registration number: _____ - _____ 3. Location code, if any: 9 8 - _____

Plan Information

4. This application is for a (check one): ☐ New plan ☐ Modification of an existing plan
5. On what date do you want this plan to start? It must be a Monday. _____

Contact Information

6. Contact person's name: _____
7. Title: _____
8. Email: _____
9. Mailing address:
   - 9a. Number and street: _____
   - 9b. City: _____ 9c. State: _____ 9d. Zip: _____
10. Business phone with area code: _____ ext. _____

Employee Information

11. How many employees do you have in New York State? _____
12. Please estimate how many employees would have been laid off without the Shared Work Program: _____
13. Are any employees who will take part in this program paid wages earned from piece work? ☐ Yes ☐ No

    If yes, give details about the piece work arrangements. Supply copies of any agreements or descriptions of how the employees are paid.

14 Collective Bargaining Agent(s) Consent

1. Union Name: _____
Local Number: _____
Name: _____
Title: _____
Street: _____
City: _____
State: _____ Zip: _____
Phone: _____ ext. _____
Signature: _____

2. Union Name: _____
Local Number: _____
Name: _____
Title: _____
Street: _____
City: _____
State: _____ Zip: _____
Phone: _____ ext. _____
Signature: _____

If you have additional Collective Bargaining Agents, provide their information on a separate sheet and attach it to this application.

Employer Certification

I certify to the following:

A. The employees' health insurance, medical insurance, retirement or any other fringe benefit in effect prior to this Shared Work application will not be eliminated or diminished unless such benefits are eliminated or diminished for the entire work force.

B. The union(s) representing the employees identified as participants have reviewed and provided written consent to the plan. This consent will be retained and produced upon request.

C. Without the Shared Work Program, I would be laying off workers.
   - The reduced or restricted hours for all employees included in this Shared Work Program equals the hours that would be lost from the laid off workers.

D. Additional employees will not be hired for the affected group for the duration of the plan.

E. Shared Work benefit payments may be charged to my unemployment insurance account (experience rated or reimbursable).

F. I agree that no participant of the program shall receive in total more than twenty-six weeks of benefits, excluding the waiting week.

G. I have provided notification of the proposed Shared Work Plan to my workforce.
   - If I am unable to provide such notification, I have provided an explanation on a separate sheet included with this application.

H. I have provided in question 12 an accurate estimate of the number of employees who would be laid off if I am unable to participate in the Shared Work Program.

I. The terms and implementation of this plan will fully comply with employer obligations under applicable federal and state laws.

J. The Commissioner will receive reports necessary for the proper administration of the plan upon request. The Commissioner can access all records necessary to verify the plan before approval and to evaluate its use.

Signature of Corporate Officer, Sole Proprietor or General Partner:

_____ Date: _____

Type or print name: _____

Title: _____